Medicare Part B vs. Medicare Part D
Drug Request Form

BlueCross BlueShield of North Carolina

To submit request electronically, please go to covermymeds.com using Plan/PBM Name “BCBS NC”

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information
Physician Name:	NPI #:	Patient Name:
Office Contact Person:		Patient ID #:
Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State:	Zip:	DOB:

Diagnosis and Medication Information	
Drug Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Certain drugs may be covered under Medicare Part B or Medicare Part D and therefore, require prior review to determine the entity responsible for coverage (see CMS Coverage database https://www.cms.gov/medicare-coverage-database/ or DME-MAC Jurisdiction C http://www.cgsmedicare.com/jc/coverage/lcdinfo.html for Part B drug coverage clarification).

1. Is this request for an expedited review?............ ☐ Yes ☐ No

   Check the “Yes” box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. **Please indicate if the requested medication is a:**

   ☐ brand-name product ☐ generic product

3. **Please identify where the requested medication will be administered to the patient:**

   ☐ Inpatient hospital ☐ Outpatient facility ☐ Office setting ☐ Home
   ☐ Pharmacy ☐ Skilled Nursing Facility ☐ Hospice ☐ Long Term Care
   ☐ Other (specify):________________

   A. If place of service is **outpatient or office**, will the requested medication be billed by that location?............ ☐ Yes ☐ No

4. **Is the requested medication an oral anti-emetic being prescribed for nausea and/or vomiting related to any of the following conditions?**

   A. Chemotherapy-induced nausea/vomiting............ ☐ Yes ☐ No
      i. **If YES, please answer question 5 on next page.**
   B. Post-operative nausea/vomiting............ ☐ Yes ☐ No
   C. Medication-induced nausea/vomiting............ ☐ Yes ☐ No
   D. Radiation-induced nausea/vomiting............ ☐ Yes ☐ No
   E. Other............ ☐ Yes ☐ No
      i. **If YES, please specify condition:** ________________________________

PLEASE CONTINUE TO NEXT PAGE

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5. **For oral anti-emetics prescribed for chemotherapy-induced nausea/vomiting, please answer the following questions:**
   - A. Is the patient receiving oral chemotherapy? ☐ Yes ☐ No
     - i. **If YES**, please answer the following questions:
       - a. List the names of all oral chemotherapeutic agents the patient will receive:________ ____
       - b. Is it likely that the anti-cancer drug will cause vomiting if the requested oral anti-emetic is not given? ☐ Yes ☐ No
       - c. Will the patient receive the oral anti-emetic within 2 hours before the oral anti-cancer drug is given? ☐ Yes ☐ No
   - B. Is the patient receiving IV chemotherapy? ☐ Yes ☐ No
   - C. Will the patient receive the oral anti-emetic within 2 hours of chemotherapy administration? ☐ Yes ☐ No
     - i. **If YES,** will the patient take the oral anti-emetic beyond 48 hours of receiving chemotherapy? ☐ Yes ☐ No
   - D. Will the oral anti-emetic be used as a full therapeutic replacement for IV anti-emetic drugs as part of an IV cancer chemotherapeutic regimen (i.e., patient is **not** receiving an IV anti-emetic)? ☐ Yes ☐ No
   - E. Will the oral anti-emetic be used with other oral anti-emetic medications? ☐ Yes ☐ No
     - i.. **If YES,** please list the names of all oral anti-emetics **and** IV chemotherapeutic agents the patient will receive:____ ____

6. **Is the requested medication used in a nebulizer?** ☐ Yes ☐ No
   - A. **If YES**, please answer the following questions:
     - i. Is the patient currently in a Skilled Nursing Facility or hospital? ☐ Yes ☐ No
       - a. **If YES,** has the patient exhausted all Medicare Part A benefits? ☐ Yes ☐ No
     - ii. Please list the names of all medications previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request:____ ____

7. **Is the requested medication an immunosuppressant related to organ transplant?** ☐ Yes ☐ No
   - A. **If YES**, please answer the following questions:
     - i. Please indicate the organ transplanted:____________________
     - ii. Did Medicare cover the transplant? ☐ Yes ☐ No
   - B. **If kidney transplant**, please answer the following questions:
     - i. Please provide the date of the transplant:______/______/________
     - ii. Was end stage renal disease the sole reason the patient was enrolled in Medicare? ☐ Yes ☐ No

8. **Is the requested medication related to End Stage Renal Disease (ESRD)?** ☐ Yes ☐ No
   - A. **If YES**, is the patient currently receiving dialysis? ☐ Yes ☐ No

9. **Is the requested medication insulin?** ☐ Yes ☐ No
   - A. **If YES**, please answer the following questions:
     - i. Is the insulin used in an insulin pump? ☐ Yes ☐ No
       - a. **If YES,** is it a non-disposable insulin pump? ☐ Yes ☐ No
     - ii. Please list the names of all insulin products previously tried and failed or to which the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to related to this request: ____ ____

10. **Additional information we should consider** (attach any supporting documents): ________________ ____

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:____ Date: ________________

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